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Supreme Court of the United States

DAVID KING, *et al.*,
Petitioners,
v.
SYLVIA MATHEWS BURWELL, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION, FEDERATION OF AMERICAN HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND AMERICA'S ESSENTIAL HOSPITALS AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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STATEMENT OF INTEREST[1]

The American Hospital Association, Federation of American Hospitals, Association of American Medical Colleges, and America's Essential Hospitals respectfully submit this brief as *amici curiae*.

[1] No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than *amici curiae*, their members, or counsel made any monetary contribution intended to fund the preparation or submission of this brief. All parties have given their consent to this filing in letters that have been lodged with the Clerk.

The American Hospital Association represents more than 5,000 hospitals, health care systems, and other health care organizations, plus 42,000 individual members. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available to and affordable for all Americans. The AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health policy.

The Federation of American Hospitals is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Dedicated to a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

The Association of American Medical Colleges is a not-for-profit association representing all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 83,000 medical students, and 110,000 resident physicians.

America's Essential Hospitals, formerly the National Association of Public Hospitals and Health Systems, is a champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. Its membership comprises more than 250 essential hospitals and health sys-

tems across the country which predominantly serve patients covered by public programs and the uninsured. Since 1981, America's Essential Hospitals has initiated, advanced, and preserved programs and policies that help these hospitals ensure access to care.

Amici's members are deeply affected by the nation's health care laws, particularly the Affordable Care Act (ACA). And the subsidies Congress built into the ACA are critical to the law's success. Access to those subsidies in *all* States, not just some, has a profound positive impact on both patients and hospitals. Suddenly withdrawing those subsidies would add millions of Americans to the ranks of the uninsured, denying them the security and benefits of health coverage. *Amici* write to offer guidance, from hospitals' perspective, on the impact Petitioners' position would have on American health care if they prevail.

SUMMARY OF ARGUMENT

We will not mince words: Petitioners' position, if accepted, would be a disaster for millions of lower- and middle-income Americans. The ACA's subsidies have made it possible for more than 9 million men, women, and children to have health care coverage—some for the first time in years; some, no doubt, for the first time in their lives. That coverage allows them to go to the doctor when they are sick, and to do so without fear that the resulting bill could leave them in financial distress. If Petitioners' interpretation is accepted, however, that salutary development will be reversed. The ranks of the uninsured will swell again, with all that portends in the way of untreated illness and overwhelming debt.

That—emphatically—is not what Congress intended when it enacted a statute to create "near-universal coverage." 42 U.S.C. § 18091(2)(D). More importantly, it is not what Congress wrote. One clause of Section 36B might support Petitioners' position when read in total isolation. But when read in light of the ACA's definitions of the word "Exchange" and the rest of the Act's text and structure—as it must be—the clause does not. It instead extends subsidies to residents across the country. This Court should so hold. And it should reject Petitioners' contrary interpretation, which creates absurdities across the statute that Petitioners cannot explain.

ARGUMENT

I. ELIMINATING SUBSIDIES IN STATES WITH FEDERALLY FACILITATED EXCHANGES WOULD SEVERELY HARM MILLIONS OF AMERICANS AND THE HOSPITALS THAT SERVE THEM.

Petitioners' case is based on a technicality, but there is nothing technical about the consequences of their position: It would strip insurance coverage away from millions of Americans. And it would devastate some hospitals and leave others without the resources they need to serve their communities—especially the most vulnerable.

A. Subsidies Are Critical To Make Insurance Affordable, And Eliminating Them In Many States Would Cost Millions Of People Coverage.

1. The ACA created health-insurance Exchanges to serve the individual and small-group health insurance markets. 42 U.S.C. §§ 18031-18044. Through

the Exchanges, qualified individuals can purchase health-insurance plans that provide a comprehensive essential health benefits package. *Id.* § 18021(a)(1)(B). Although rates on the Exchanges are lower than many initially expected, *see* L. Skopec & R. Kronick, Dep't of Health & Human Servs., *Market Competition Works: Proposed Silver Premiums in the 2014 Individual and Small Group Markets Are Nearly 20% Lower than Expected*,[2] they are still high enough that—just as before the ACA—many lower- and middle-income Americans cannot easily afford to buy coverage, *see* J. Cohn, *Five Things We Know About Obamacare—And One We Don't*, The New Republic, Sept. 6, 2013.[3]

Congress understood the affordability issue. It therefore built into the Exchanges a system of tax credits that act as subsidies, reducing the cost of Exchange-offered plans for those with household incomes from 100%-400% of the federal poverty level. *See* 26 U.S.C. § 36B. Though the amounts depend on the plan level and a patient's household income, the subsidies are often quite substantial. More than 85% of enrollees on federally facilitated Exchanges in 2014 were approved for advance payments of the tax credits, and the credits financed more than three-quarters of those customers' premiums—many thousands of dollars per enrollee. *See* U.S. Br. 11; *see also* CBO, *Insurance Coverage Provisions of the Affordable Care Act—CBO's January 2015 Baseline* tbl.B-2 (Jan. 2015).[4]

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[2] *Available at* http://goo.gl/XLhpEY.

[3] *Available at* http://goo.gl/SqjF3U.

[4] *Available at* http://goo.gl/wieEZE.

A few examples illustrate the dramatic effect subsidies can have. According to a recent calculation, a 60-year-old couple in Los Angeles with a $30,000 income would have to spend $1,092 per month—or about $13,000 per year, nearly half of their total income—to buy an unsubsidized "silver" plan. With the ACA's subsidies, that plan would cost $148 per month, which is less than 6 percent of their total income. C. Cox, *et al.*, Kaiser Family Foundation, *Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces*, at 7 (Sept. 2014).[5] Likewise, a family of four making $60,000 per year in New York City would have to spend $1,034 per month before the subsidy but will pay only $407 per month with it. *Id.* at 15. And a single 25-year-old in Burlington, Vermont making $25,000 per year would have to pay $1,143 per month without the subsidy but will pay only $440 per month with it. *Id.* at 20.

These are not outliers, either. A recent study concluded that if subsidies are invalidated in States with federally facilitated Exchanges, the cost of coverage for the poorest enrollees would skyrocket from 3.6 percent of their income to *48.9 percent* of their income for family policies. Robert Wood Johnson Foundation, *Characteristics of Those Affected by a Supreme Court Finding for the Plaintiff in* King *v.* Burwell 1 (Jan. 2015) (*Characteristics*).[6]

The bottom line: The ACA's subsidies are often the difference between health coverage that is affordable for lower- and middle-income Americans and health

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[5] *Available at* http://goo.gl/M2i5L6.

[6] *Available at* http://goo.gl/go8c8Z.

coverage that is not. Without the subsidies, many Americans would be forced to choose between continuing to pay for health insurance and paying for basic necessities like rent and food.

2. Petitioners' bid to eliminate subsidies for those who purchase policies through federally facilitated Exchanges, if accepted, would cost millions of Americans comprehensive coverage.

Recent studies quantify the problem. The Robert Wood Johnson Foundation estimates that if Petitioners prevail, enrollment in Exchange-offered plans as of 2016 would plunge by close to 10.2 million people, 9.3 million of whom were receiving subsidies. L.J. Blumberg, *et al.*, The Robert Wood Johnson Foundation, *The Implications of a Supreme Court Finding for the Plaintiff in* King *v.* Burwell*: 8.2 Million More Uninsured and 35% Higher Premiums* 3 tbls. 1 & 2 (Jan. 2015) (*Implications*).[7]

The harm would not stop at those who use subsidies to buy insurance on federally facilitated exchanges. The disappearance of subsidies also would cause overall premiums in the individual insurance market to skyrocket by 35% to 47%—a jump of $1,460 to $1,610 per year. *Implications*, *supra*, at 6 (estimating 35%); E. Saltzman & C. Eibner, RAND Corporation, *The Effect of Eliminating the Affordable Care Act's Tax Credits in Federally Facilitated Marketplaces* 5 (2015) (estimating 47%) (*Effect of Eliminating Credits*).[8] That in turn means many of those who buy through Exchanges, or on a separate market, would no longer be able to afford coverage. For

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[7] *Available at* http://goo.gl/WbBFcU.

[8] *Available at* http://goo.gl/WX9Jxg.

example, with the loss of subsidies and increase in rates combined, that 25-year-old in Burlington could go from paying $5,280 a year for health insurance to as much as $20,162—a clearly prohibitive amount for him, and for most lower- and middle-income Americans.

Overall, a net 8.2 million more Americans would be uninsured after a ruling for Petitioners. *Implications*, *supra*, at 4-5. Most of those losing coverage would be self-employed workers, workers at small companies, and their families. *Characteristics*, *supra*, at 1.

B. The Loss Of Coverage Would Be Devastating For Many Americans.

1. This en masse loss of coverage will devastate the health or the finances, or both, of the newly uninsured. Kaiser Comm'n on Medicaid & the Uninsured, *The Uninsured & the Difference Health Care Makes* 2 (Sept. 2010) (*Difference Health Care Makes*).[9] The uninsured are more than twice as likely to delay or forgo needed care, *id.*, and when they do visit the doctor the resulting bills are often too much for them to bear. *See* 42 U.S.C. § 18091(2)(G). The point cannot be overemphasized: This is no abstract case about principles of statutory construction. Petitioners' position, if accepted, means many more people will get sick, go bankrupt, or die.

Nor will hospitals' open-door policies suffice to ward off those harms. Hospitals treat all emergency cases without regard to ability to pay, and many uninsured Americans accordingly rely on emergency

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[9] *Available at* http://goo.gl/mh6s01.

rooms to serve as their *de facto* primary care providers and to treat acute conditions. *See, e.g.*, M. William Salganik, *ER Use by Uninsured Disproportionately High*, The Baltimore Sun, Jan. 31, 2001.[10] But that is no substitute for regular treatment; putting off needed care until it is an emergency leads to far poorer outcomes for many patients. *Difference Health Care Makes*, *supra*, at 2. Exchange-offered plans empower the uninsured to purchase comprehensive insurance so they can receive care in more appropriate settings, benefiting patients and reducing health-care costs across the board. *See* S.M. Miller, Robert Wood Johnson Foundation, *The ACA Helps Correct Incentives for Patients to Use the Health Care System Inefficiently* (Aug. 30, 2013).[11]

Indeed, the ACA-driven expansion in health coverage already has had a demonstrable positive impact. One recent study found that the ACA—and in particular the availability of subsidies—has driven the number of American uninsured down sharply, from 37 million people in 2010 to 29 million in 2014. S.R. Collins, *et al.*, The Commonwealth Fund, *The Rise in Health Care Coverage and Affordability Since Health Reform Took Effect* 1 (Jan. 2015).[12] The effects were immediate: For the first time since 2003, "there was a decline in in the number of adults who reported not getting needed care because of cost." *Id.* Moreover, there was "a decline in the number of people who had problems paying their medical bills or who are paying off medical debt over time." *Id.* Eliminating subsidies for those in States

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[10] *Available at* http://goo.gl/3zhQy9.

[11] *Available at* http://goo.gl/WZqswU.

[12] *Available at* http://goo.gl/Lc1QXy.

with federally facilitated Exchanges will undo these significant strides.

2. The harms described above will be particularly devastating because lower-income residents in the affected States—those with federally facilitated Exchanges—can least afford to lose subsidies, and the States where they live are poorly positioned to fill the gap.

a. States with federally facilitated Exchanges have higher-than-average populations of low-income people. *Effect of Eliminating Credits*, *supra*, at 6. Those residents "receive larger subsidies" than residents of other States on average, and their "insurances decisions are more sensitive to price than higher-income people." *Id.* Moreover, States with federally facilitated Exchanges "had higher rates of uninsurance before the passage of the ACA, further expanding the pool of potential enrollees who would benefit from subsidies"—and increasing the harm if subsidies are stripped away. *Id.*

To make matters worse, many of the States with federally facilitated Exchanges are the same ones that refused to expand Medicaid coverage. The ACA as originally designed expanded Medicaid to all non-disabled adults with income at or below 138% of the poverty level; the idea was to cover Americans who could not afford insurance through the Exchanges but made slightly too much money to be Medicaid-eligible. Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* 2 (Nov. 2014) (*The Coverage Gap*).[13] However, in light of this Court's ruling that

[13] *Available at* http://goo.gl/uEcYbD.

the Medicaid expansion is optional, *see National Fed. of Indep. Business* v. *Sebelius*, 132 S. Ct. 2566, 2609 (2012), 23 States have declined to expand it, *The Coverage Gap, supra*, at 1.

Experts to this point have assumed that the Exchanges could help some of those left behind. The CBO, for example, has estimated that 2 million of the 6 million people denied expanded Medicaid coverage will enroll through Exchanges using subsidies, mitigating—at least somewhat—the impact in those States. CBO, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision* 12 & tbl.1 (July 2012).[14] If Petitioners prevail, however, most of these 2 million will not be able to afford coverage through the Exchanges. That is because of the 23 States opting out of the Medicaid expansion, all but one have federally facilitated Exchanges. *Compare The Coverage Gap*, *supra*, at 1, *with* The Commonwealth Fund, *State Action to Establish Health Insurance Marketplaces* (Mar. 2014).[15] In those States, individuals making 100% to 138% of the poverty level—about $11,670 to $16,100 per year[16]—would have to seek coverage on the market with no subsidies at all. They would face premiums they could not possibly pay. *See supra* at 5-6.

Petitioners' position also would hurt the children of moderately low-income families. These children may be eligible for the Children's Health Insurance Program (CHIP), which "provides health assistance

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[14] *Available at* http://goo.gl/eZiU3B.

[15] *Available at* http://goo.gl/3tOUxs.

[16] U.S. Dep't of Health & Human Servs., *2014 Poverty Guidelines*, *available at* http://goo.gl/Rd6b9L.

to uninsured, low income children whose family income is above the state's Medicaid income limits, but who cannot afford private health insurance." *Julia M.* v. *Scott*, 498 F. Supp. 2d 1245, 1246 (W.D. Mo. 2007). But "[w]ithout tax credits, fewer parents would seek marketplace coverage, and, as a result, fewer children would be screened for and enrolled in public insurance" through CHIP. *Implications*, *supra*, at 4. As a result, analysts estimate that Petitioners' position would leave 500,000 additional lower-income children uninsured. *Id.*

Petitioners' position thus would not only deny millions access to coverage. It would deny access to those who need it most: low-income Americans who are not eligible for Medicaid and their children.

C. Eliminating Subsidies Would Harm Hospitals And Make It More Difficult For Them To Serve Their Communities.

While harm to individuals must be the foremost consideration, the Court should be aware of a second consequence of Petitioner's position: Hospitals will incur significant financial harm if subsidies suddenly disappear across much of the country. In the ACA, Congress imposed deep cuts to federal funding for hospitals. But it expected that the subsidies it included in the statute would bring newly insured patients to hospitals, helping them offset the loss. An ACA without subsidies would leave hospitals unable to make up the loss in their funding. That could imperil some hospitals, and will make it more difficult for others to carry out their missions, including effectively serving their communities.

1. Congress in the ACA cut the payments hospitals receive to care for Medicare and Medicaid patients in two primary ways.

First, Congress cut Medicare and Medicaid Disproportionate Share Hospital, or "DSH," payments. 42 U.S.C. § 1395ww(r) (Medicare); *id.* § 1396r-4(f)(7) (Medicaid). DSH payments provide assistance to hospitals that serve large numbers of low-income patients, *see Sebelius* v. *Auburn Reg'l Med. Ctr.*, 133 S. Ct. 817, 822 (2013), and are the largest form of federal funding for uncompensated care, *see* Kaiser Family Foundation, *Uncompensated Care for the Uninsured in 2013: A Detailed Examination* (May 30, 2014).[17] Together, the ACA's reductions in Medicare and Medicaid DSH payments will cut federal support for uncompensated care by an estimated $36.1 billion over the next decade. *See* American Hosp. Ass'n, *Summary of 2010 Health Care Reform Legislation* 34-35 (Apr. 19, 2010).[18]

Second, Congress cut payments to hospitals by reducing the Medicare inflation adjustment and the "market basket" rates used annually to adjust Medicare payments. 42 U.S.C. § 1395ww(b)(3)(B). The program's chief actuary has estimated that these cuts will cost hospitals another $233 billion over 10 years. Richard S. Foster, Chief Actuary, Ctrs. for Medicare & Medicaid Servs., *The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures* (Mar. 30, 2011).[19]

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[17] *Available at* http://goo.gl/bF3k0O.

[18] *Available at* http://goo.gl/vBafWp.

[19] *Available at* http://goo.gl/8FpZBm.

The cuts—a combined total of some *$269 billion* in a single decade—drastically reduce hospitals' payments for treating Medicare and Medicaid patients. That is particularly significant because even before the cuts, Medicare and Medicaid did not fully cover hospitals' costs of care. Hospitals in 2012 alone spent $56 billion providing care to Medicare and Medicaid patients for which the hospitals were not reimbursed. American Hosp. Ass'n, *Trendwatch Chartbook 2014* tbl.4.5 (2014).[20]

2. Congress thought hospitals could survive these cuts because they would receive offsetting revenues. Specifically, lawmakers believed the newly freed-up monies would fund subsidies; the subsidies in turn would help more people buy insurance; and the influx of insured patients would reduce—though not eliminate—the billions of dollars a year that hospitals spend providing uncompensated care. *See* 42 U.S.C. § 18091(2) (congressional findings). As President Obama explained: "As health reform phases in, the number of uninsured will go down, and we would be able to reduce payments to hospitals for treating those previously uncovered." L.D. Hermer & M. Lenihan, *The Future of Medicaid Supplemental Payments: Can They Promote Patient-Centered Care?* 102 Ky. L.J. 287, 294 n.37 (2013) (quoting press reports). The inflation and market-basket adjustments had a similar impetus. *See* J. Reichard, *Biden Announces Deal With Hospitals to Cut Medicare, Medicaid Payments By $155 Billion*, CQ Healthbeat, July 8, 2009.[21]

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[20] *Available at* http://goo.gl/1IIYfn.

[21] *Available at* http://goo.gl/HoAwVU.

And indeed, although the ACA's rollout has hardly been perfect, some hospitals have begun to see an increase in insured patients and a corresponding decrease in uncompensated care. *See* PricewaterhouseCoopers, *The Health System Haves and Have Nots of ACA Expansion* 3 (2014).[22] Major hospital systems have seen drops of as much as 48 percent in self-pay patients—the patients most likely to be sicker when they apply for care and unable to pay for it at reduced Medicare rates. *Id.* And the Department of Health and Human Services has estimated that newly insured patients will reduce hospitals' uncompensated-care burden by $1.5 billion in 2014 alone. T. DeLeire, *et al.*, *Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014*, at 20 (Sept. 24, 2014).[23]

3. Without subsidies in States with federally facilitated Exchanges, however, Congress's carefully calibrated trade-off would fall apart. A market without subsidies will trigger a premium "death spiral" in those States: With subsidies gone and premiums pushed higher, younger and healthier patients will likely drop coverage. Those that remain, paying the higher rates, are likely to be sicker and use more health-care resources. That, in turn, will push rates for everyone in those States even higher, which will cause more to drop coverage, and so on. *See* Pet. App. 30a; J. Rovner, *If High Court Strikes Federal Exchange Subsidies, Health Law Could Unravel*, Kaiser Health News, Dec. 2, 2014.[24] The result: Hospitals would be subsidizing as much

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[22] *Available at* http://goo.gl/6BrvIM.

[23] *Available at* http://goo.gl/K507Lz.

[24] *Available at* http://goo.gl/72gcfx.

uncompensated care as ever, if not more, but without the federal funds that used to help narrow the gap. *Id.*

The experience of hospitals in States that have declined to expand Medicaid offers a preview of what could follow if subsidies are stripped away.

In those States, hospitals have been subject to the ACA's reimbursement cuts but have not seen the cuts mitigated by new Medicaid patients. As a consequence, hospitals—particularly rural and safety-net hospitals—have been forced to curtail services, and in some cases to close altogether. For example, five Georgia hospitals have closed since 2013, and many others are in financial distress. A. Miller, *Will Ga. Hospital Group Go To Bat For Expansion?*, Georgia Health News, Jan. 11, 2015.[25] In all, 43 rural hospitals have closed since 2010, with the pace quickening each year. J. O'Donnell & L. Ungar, *Rural Hospitals in Critical Condition*, USA Today, Nov. 12, 2014.[26]

These closures are painful for the hospitals and those who work there, of course. But they are worse for patients and for the communities the hospitals served. In rural areas, when one hospital closes, the next closest is often more than 20 miles away—and often as many as 100 miles away in States with large, sparsely populated regions, such as Colorado. *Id.* Those distances can cost lives. The Stewart County, Georgia coroner recently identified at least two deaths that could have been prevented had a closed hospital remained open. *Id.*

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[25] *Available at* http://goo.gl/0OZlvr.

[26] *Available at* http://goo.gl/npGtmk.

There are other ripple effects for the community as well. Hospitals are often major community employers. *Id.* The closure of a hospital can result in layoffs of its workers, as well as at nearby physician practices, medical suppliers, and pharmacies. *See id.*; *see also* P. Cunningham, *Insurance for the Future*, Arkansas Hospitals, Winter 2015, at 24, 27. If this Court were to vacate the IRS rule, these impacts would be felt far more broadly. That would result in reduced services for communities with critical need and fewer skilled jobs, including in rural areas, where they are in especially short supply.

America's safety-net hospitals—those that serve disproportionately needy populations—face similar threats. These hospitals generally operate with very thin, often negative, margins, and a disturbing number are already on thin fiscal ice even *with* subsidies. *See* Modern Healthcare, *Safety Net Hospitals Face Looming Care Crisis*, Nov. 21, 2014 (225 safety-net hospitals that rely heavily on DSH payments are considered to be in "weak financial shape").[27] Some of these hospitals will be imperiled by the DSH cuts, even in States that are participating fully in Medicaid expansion. See K. Neuhausen, *et al.*, *Disproportionate-Share Hospital Payment Reductions May Threaten the Financial Stability of Safety-Net Hospitals*, Health Affairs, June 2014. If subsidies are eliminated too, it would seriously threaten the financial stability of safety-net hospitals in all States and would disparately impact the vulnerable populations that these hospitals serve.

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[27] *Available at* http://goo.gl/n88AfM.

The serious financial impacts on hospitals from Petitioners' interpretation are too important for the Court to ignore. At the end of the day, hospitals must be allowed to cover their costs. If they cannot, patients will suffer in the long run.

II. THE AFFORDABLE CARE ACT MAKES SUBSIDIES AVAILABLE IN EVERY STATE.

Subsidies thus are crucial to making the ACA work, and the loss of subsidies would profoundly harm millions of Americans. Congress understood as much when it wrote the Act. And the text Congress enacted reflects that understanding: It makes subsidies available nationwide. Petitioners' contrary arguments are unavailing.

A. The Statute's Plain Text Makes Subsidies Available Nationwide.

Section 36B makes a person eligible for subsidies if he or she enrolls in coverage "through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act." 26 U.S.C. § 36B(c)(2)(A). Petitioners believe that language supports their quest to cut off subsidies, but it does not. On the contrary, the Act's definitional sections make clear that Section 36B extends subsidies to residents of *every* State, including those with federally facilitated Exchanges.

The United States explains why. U.S. Br. 19-23. The heart of the analysis is simple and compelling: "Exchange" is a defined term that always means "an American Health Benefit Exchange established *under Section [1311]* of this title." 42 U.S.C. § 300gg-91(d)(21) (emphasis added). Section 1311, in turn, provides that each State "shall * * * establish" an

Exchange, 42 U.S.C. 18031(b)(1), and that by definition an Exchange "shall be a governmental agency or nonprofit entity that is *established by a State*," *id.* § 18031(d)(1) (emphasis added).

Putting the pieces together, the term "Exchange" is defined throughout Title I to mean an Exchange established (i) by a State and (ii) under Section 1311. Thus when the federal government launches "*such Exchange*," *id.* § 18041(c)(1) (emphasis added), it is still an Exchange established "by a State" "under Section [1311]," by statutory definition. And Section 36B's reference to "an Exchange established by the State under section 1311," 26 U.S.C. § 36B(c)(2)(A), is just a word-for-word reiteration of the statutory definitions of "Exchange." The phrase is a statutorily defined "term of art." U.S. Br. 20. It makes subsidies available on *all* Exchanges, not a limited subset. *See id.* at 19-23.

Petitioners say the phrase "such Exchange" cannot bear the weight the government puts on it. As an analogy, they suggest that if Congress told States to construct airports, "but then added that the U.S. Secretary of Transportation should construct 'such airports' if states fail to do so, nobody would ever think to refer to the latter as 'State-constructed airports.' Pet. Br. 22-23. This argument only underscores the degree to which Petitioners ignore the ACA's statutory definitions of "Exchange." To make Petitioners' hypothetical truly analogous, their statute would have to define the word "airport" to mean an airport "constructed by a State" and designed and built in accordance with detailed congressional instructions. If the statute so provided, then it would make perfect sense to say that "such airports"

are constructed by the State as a matter of statutory definition, no matter who took the laboring oar. So it is here: The statutory definitions and the phrase "such Exchange" make "Exchange established by the State" a term of art encompassing all Exchanges that serve the citizens of a State, regardless of who operates them.

B. The "Qualified Individuals" Provision Underscores The Impossibility Of Petitioners' Interpretation.

Petitioners' contrary interpretation thus gives short shrift to key statutory definitions. Just as importantly, it renders other parts of the statute nonsensical. That latter flaw is not just some small hiccup for Petitioners, as they would have it—it is fatal to their position.

1. Statutory construction "is a holistic endeavor," *United Sav. Ass'n of Texas* v. *Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988), and it is this Court's "role to make sense rather than nonsense out of the *corpus juris*," *West Va. Univ. Hosps., Inc.* v. *Casey*, 499 U.S. 83, 101 (1991). That in turn means a proposed statutory interpretation that "makes nonsense of" an adjacent provision, rendering it "a practical nullity and a theoretical absurdity," cannot be correct. *United Sav. Ass'n*, 484 U.S. at 374-375; *accord University of Texas Southwestern Med. Ctr.* v. *Nassar*, 133 S. Ct. 2517, 2529 (2013). When an interpretation is flawed in this way, that fact "suffices to dispose of petitioner's contention." *General Motors Corp.* v. *United States*, 496 U.S. 530, 537 (1990).

So it is here. The United States explains the many anomalies created by Petitioners' interpretation. *See*

U.S. Br. 27-33, 51-54. *Amici* will not repeat that discussion. They instead will drill down on the most glaring problem with Petitioners' reading: If it is correct, then *no one is eligible to use the Exchanges in 34 States*, because those States contain no "qualified individuals." Every federally facilitated Exchange would be a pointless marketplace with no customers. Congress did not intend such an absurd result.

2. Sections 1311 and 1312 set a key ground rule for the Exchanges: Only "qualified individuals" may use them. *See* 42 U.S.C. § 18031(d)(2)(A) (Exchanges "shall make available qualified health plans to qualified individuals[.]"); *id.* § 18032(a)(1) ("A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible."). And Section 1312 defines "qualified individual" to mean "an individual who * * * *resides in the State that established the Exchange*." *Id.* § 18032(f)(1)(A) (emphasis added). Thus only someone who lives in the "State that established the Exchange" is a "qualified individual" eligible to use the Exchange.

On Petitioner's reading, there are zero "qualified individuals" in the 34 States with federally facilitated exchanges. After all, in those States no one "resides in the State that established the Exchange," *id.*, because the State did not establish the Exchange at all. Petitioner's reading thus creates a situation where federal Exchanges (i) were expressly created by statute, (ii) are up and running in 34 States, and yet (iii) are forbidden by the same statute from doing anything at all. As Judge Friedman recognized, they "would have no customers, and no purpose." *Halbig* v. *Sebelius*, 27 F. Supp. 3d 1, 22 (D.D.C. 2014).

Petitioners' interpretation is therefore fatally flawed. Because it "makes nonsense of" an adjacent provision, rendering it "a practical nullity and a theoretical absurdity," it cannot be correct. *United Sav. Ass'n*, 484 U.S. at 374-375.

3. Petitioners and their *amici* cobble together no less than six different theories to explain away the "qualified individuals" problem. Their explanations range from demonstrably wrong to absurd.

a. Petitioners argued below that "the solution" to the anomaly their interpretation creates "is to excise the words causing the absurdity," so that Section 18032 says " 'reside in the State,' " instead of "reside in the State that established the Exchange." C.A. Opening Br. 32. It is worth pausing on that sentence: Petitioners suggest that the Court should *rewrite the statute* to avoid the absurdity *Petitioners themselves* have created. That suggestion "is a telltale sign that their reading of section 36B is wrong." Pet. App. 65a. It is also legally unsound: This Court is not at liberty to "excise the words" from statutes. Where a litigant's interpretation would "make nonsense of" an adjacent provision, rendering it a "practical nullity," this Court concludes that the litigant's interpretation is incorrect. *United Sav. Ass'n*, 484 U.S. at 374-375. It does not redraft the statute to rescue the litigant's argument.

b. Petitioners likewise argue that "the qualified-individual definition only applies to state Exchanges, so it inherently cannot limit the individuals eligible for enrollment on HHS Exchanges." Pet. Br. 48. Here is their explanation:

> The Act defines "qualified individual" "with respect to an Exchange." 42 U.S.C. § 18032(f)(1)(A). Since "Exchange" is itself defined as an "Exchange established under section 1311," 42 U.S.C. § 300gg-91(d)(21), the definition of "qualified individual" is quite naturally construed as applying only to § 1311 state-run Exchanges.

Id. That argument makes no sense on multiple levels. First, Petitioners themselves say earlier in their brief that when the Act uses "Exchange" standing alone, that must mean something different than when the Act refers to an "Exchange established by the state." Pet. Br. 27-28. And yet to escape their qualified-individuals anomaly, they pivot 180 degrees and argue that the word "Exchange" standing alone *does* mean Exchange established by the State. Petitioners cannot have it both ways.

Second, the Act cannot plausibly be read to limit the definition of "qualified individuals" to only state-run Exchanges. The term "qualified individuals" is a key piece of the ACA. It appears 31 times in the Act, and it sets the general ground rules for everything from who may enroll in health care plans, to who may not (e.g., incarcerated individuals and illegal aliens), to who may serve as a "navigator" on Exchanges, to eligibility for catastrophic plans. *See, e.g.*, 42 U.S.C. §§ 18031(i), 18032(d)(3), 18032(f), 18051. Petitioners' facile suggestion that the term applies only to state-run Exchanges would leave gaping holes in the law.

c. Petitioners next argue that "the Act never actually limits enrollment on Exchanges to 'qualified individuals,' so even if no qualified individuals existed for HHS Exchanges, that would not preclude

enrollment." Pet. Br. 49. That is so, they say, because "§ 1312 of the ACA says only that a qualified individual 'may enroll in any qualified health plan available to such individual and for which such individual is eligible.' It does not say others are barred." *Id.* (quoting 42 U.S.C. § 18032(a)(1)).

This argument makes no more sense than the others. If both qualified individuals and non-qualified individuals could enroll in Exchanges, then the term "qualified individual" would be doing no work. The very *raison d'etre* of the defined term is to delimit who is "*qualified*" to enroll through Exchanges. When a statute bothers to define who is "qualified" to participate in a program, it means by necessary implication that others who do not meet that standard are *not* qualified, and may not participate. *Cf. Leavenworth, L. & G.R. Co.* v. *United States*, 92 U.S. 733, 740 (1875) ("[W]hat is not given expressly, or by necessary implication, is withheld.").

Indeed, the statutory text makes plain that that is exactly what Congress had in mind. Section 1312(f), which contains the definition of "qualified individuals," is entitled: "Qualified individuals and employers; *access limited* to citizens and lawful residents." 42 U.S.C. § 18032(f) (emphasis added). And it goes on to explain what happens if you are not a qualified individual: You cannot sign up for insurance through an Exchange. *See id.* § 18032(f)(3) (an illegal alien "shall not be treated as a qualified individual *and may not be covered under a qualified health plan in the individual market that is offered through an Exchange*") (emphasis added).[28]

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[28] Petitioners say this provision supports them because it separately says (i) illegal aliens are not qualified individuals

Other provisions confirm the point. Section 1331, for example, defines a category of "eligible individuals" who may enroll in a different ACA program. 42 U.S.C. § 18051. And in a subsection entitled, "ELIGIBLE INDIVIDUALS MAY NOT USE EXCHANGE," it provides: "An eligible individual shall not be treated as a qualified individual under section 1312 eligible for enrollment in a qualified health plan offered through an Exchange * * * ." *Id.* § 18051(e)(2). Congress thus equated "qualified individual" with eligibility to use Exchanges. It made clear that "qualified individuals" may enroll in insurance through Exchanges, and others may not.

d. Finally, Petitioners argue that "someone who seeks to enroll on an HHS Exchange does not *fail* the requirement that he 'resid[e] in the State that established the Exchange.' That requirement facially rests on the assumption that a state-established Exchange exists; if that proves false, it has no application." Pet. Br. 50.

But that is "nonsense upon stilts." *Sosa* v. *Alvarez-Machain*, 542 U.S. 692, 743 (2004) (Scalia, J., concurring). Congress provided that a person can be a "qualified individual" *only* if he or she resides in the

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and (ii) such aliens may not be covered by Exchange plans; they say qualification and eligibility must be different, else one of these clauses would be superfluous. Pet. Br. 49. But the more natural reading is that the "may not be covered" clause explains the consequences of not being a qualified individual. Petitioners' reading is the one that creates superfluity: Once the provision says aliens cannot be covered on an Exchange, the provision that they are not "qualified individuals" does no further work. *See Marx* v. *General Revenue Corp.*, 133 S. Ct. 1166, 1177 (2013) (canon against superfluity applies only where another reading avoids superfluity).

State "that established the Exchange." If no State established the Exchange, that person quite clearly flunks the requirement. Petitioners offer no authority for the notion that the requirement somehow disappears if it has not been met.

e. Petitioners' *amici* likewise try mightily to explain away the qualified-individuals anomaly, but their efforts are so weak that they only underscore the illogic of their argument.

The Adler and Cannon brief, for example argues that the definition of "qualified individual" applies only to Sections 1311, 1312, and 1313, because in those sections Congress "is speaking to the states." Br. 18. That is demonstrably wrong. The definition of "qualified individual" provides that "*[i]n this title*," qualified individual means someone who, among other things, "resides in the State that established the Exchange." 42 U.S.C. § 18032(f)(1) (emphasis added). The definition applies to the entire title, which includes Section 1321, the provision that authorizes federal exchanges.

Ignoring that statutory text, the Adler and Cannon brief presses on, arguing that "[t]he requirement that qualified individuals reside 'in the State that established the Exchange' disappears * * * in the very next section: Section 1321." Br. 18. They endeavor to explain why that is so:

> Section 1321(c) explains what happens when a state "[f]ail[s] to establish [an] Exchange." 42 U.S.C. § 18041(c). * * * In that event, "the Secretary shall take such actions as are necessary to implement such [a] requirement[]." That is, the Secretary shall require that "qualified individuals"

> must reside in the state "within" which "the Secretary * * * establish[es]" the Exchange. 42 U.S.C. § 18041(c).

Id. (second omission in Adler & Cannon brief). This argument is deeply misleading. The "requirements" that Section 18041 instructs the Secretary to implement are set forth in Section 18041(a) itself; they include things like establishing reinsurance and risk-adjustment programs. *See* 42 U.S.C. § 18041(a), (c)(1). The provision nowhere says, or even suggests, that the "requirements" language trumps the title-wide definition of "qualified individuals" set forth in Section 18032. Moreover, the last sentence of the Adler and Cannon argument quoted above—*"That is, the Secretary shall require that 'qualified individuals' must reside in the state 'within' which 'the Secretary * * * establish[es]' the Exchange. 42 U.S.C. § 18041(c)."*—is not actually a quotation from Section 18041(c), despite what the citation suggests. It is a mishmash of words drawn at random from Sections 18032 and 18041, cobbled together to create the desired effect. That is, to put it mildly, not legitimate statutory interpretation.

f. Indiana's brief takes yet another tack: It argues that Petitioners' interpretation creates no anomaly because the Secretary has provided by rule that people in States with federally facilitated Exchanges can be qualified individuals. Br. 15. That argument does not move the ball for Petitioners. Indeed, to the extent that Indiana is saying the Secretary's rule is valid, it amounts to a concession. If the key words of the qualified-individual definition—"resides in the State that established the Exchange," 42 U.S.C. § 18032(f)(1)—are capacious enough to permit the

Secretary's rule on qualified individuals, then the key words of Section 36B—"established by the State"—are capacious enough to permit the *IRS's* rule on subsidies.

Alternatively, if Indiana is saying the rule is permissible because of the Secretary's power under Section 1321(c), that too is an important concession. Section 1321(c) authorizes the Secretary to make the "other requirements" of state Exchanges also applicable to federally facilitated Exchanges. 42 U.S.C. § 18041(c)(1). If the Secretary can use that authority to apply the qualified-individual provision to federally facilitated Exchanges notwithstanding the words "State that established the Exchange" in Section 1312, then the Treasury Secretary should be able to use his authority under the similarly broad Section 36B(g) to make subsidies available on federally facilitated Exchanges notwithstanding the words "established by the State" in Section 36B.

4. Petitioners, in short, cannot explain away the absurdity created by their proposed interpretation. Under the government's approach, by contrast, the "qualified individuals" definition makes perfect sense: Residents of each State are eligible to sign up for coverage through that state's Exchange, and Exchanges have a role to play, even in States where the Exchange is federally facilitated. The government's interpretation also avoids other absurdities produced by Petitioners' approach. *See* U.S. Br. 51-54.

That is a highly relevant consideration, especially when it comes to a statute like this—that is to say, a sprawling statute thrown together quickly, with some unavoidable redundancies no matter whose

interpretation the Court accepts. A statute, after all, " 'ought to be so construed as to make it a consistent whole.' " 2A *Sutherland Statutory Construction* § 46:5 (7th ed.) (quoting *Attorney General* v. *Sillem*, 2 H&C 431, 159 Eng. Rep. 178 (1864)). But " '[i]f after all it turns out that that cannot be done, the construction that produces the greatest harmony and the least inconsistency is that which ought to prevail.' " *Id.* The government's construction meets that description here. Petitioners' does not.

C. *Bay Mills* Is Not To The Contrary.

Petitioners argue that even if their interpretation of the qualified-individuals provision is absurd, the Court should ignore the problem because " '[s]uch anomalies often arise from statutes.' " Pet. Br. 44 (quoting *Michigan* v. *Bay Mills Indian Cmty.*, 134 S. Ct. 2024, 2033 (2014)); *see also* Indiana Br. 17.

But this argument pulls the quote from *Bay Mills* far out of context. In *Bay Mills*, the statute at issue authorized a State "to sue a tribe for illegal gaming inside, but not outside, Indian country." 134 S. Ct. at 2033. Michigan urged the Court to effectively expand the statute, allowing it to sue tribes outside Indian country too, on the theory that one would expect States to have more power over tribes outside Indian country than inside Indian country. *Id.* This Court rejected the argument. It explained: "[T]his Court does not revise legislation * * * just because the text as written creates an apparent anomaly as to some subject it does not address. Truth be told, such anomalies often arise from statutes, if for no other reason than that Congress typically legislates by parts—addressing one thing without examining

all others that might merit comparable treatment." *Id.*

That principle makes perfect sense, and it has nothing to do with this case. Here, the anomaly Petitioners' reading would create is not merely one of congressional silence on a subject that might seem logical to address. It is that Congress *has* "address[ed]" the subject—it authorized federal Exchanges—and Petitioners' interpretation would render Congress' choice a nullity. In that circumstance, this Court's job is to " 'fit * * * all parts into an harmonious whole.' " *FDA* v. *Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (citation omitted). It cannot just ignore the absurdity.

D. The ACA's Purpose Also Supports The IRS's Interpretation.

Finally, while this Court need not reach issues of congressional purpose—the IRS should prevail on the plain text—the ACA's purpose clearly supports the agency's reading.

Petitioners decry any resort to what they call the "amorphous" data point of congressional purpose. Br. 33. But they ignore that this is not the typical case, where purpose must be inferred from bits and pieces of legislative history. It is, instead, the comparatively rare case where Congress's purpose is set forth right in the enacted text. Congress said, in no uncertain terms, that the ACA is designed to "*achieve[] near-universal coverage.*" 42 U.S.C. § 18091(2)(D) (emphasis added). In light of that purpose, the IRS's interpretation makes sense. Petitioners' does not. That matters: "When construing a federal statute, courts should be mindful of the

effect of the interpretation on congressional purposes explicit in the statutory text." *Jerman* v. *Carlisle, McNellie, Rini, Kramer & Ulrich LPA*, 559 U.S. 573, 618-619 (2010) (Kennedy, J., dissenting). Petitioners' arguments fly in the face of this principle.

Petitioners, of course, do not just pooh-pooh the relevance of congressional purpose and intent; they also claim indicia of that intent cuts both ways. But they have "no credible evidence whatsoever" to support the notion that Congress meant to condition subsidies on the creation of state exchanges. *Halbig* v. *Burwell*, 758 F.3d 390, 414 (D.C. Cir. 2014) (Edwards, J., dissenting). The explicit contrary purpose set forth in the ACA's text reaffirms the reasonableness of the IRS's textual interpretation. *See Mayo Found. for Med. Educ. & Research* v. *United States*, 131 S. Ct. 704, 715 (2011) (upholding Treasury regulation as reasonable under *Chevron* where it "further[ed] the purpose of the Social Security Act").

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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